Federal Update
for
April 27 – May 1, 2015

VA Construction: Actions to Address Cost Increases and Schedule Delays at Denver and Other VA Major Medical-Facility Projects

What GAO Found

In April 2013, GAO found that costs substantially increased and schedules were delayed for Department of Veterans Affairs' (VA) largest medical-facility construction projects, located in Denver, Colorado; Las Vegas, Nevada; New Orleans, Louisiana; and Orlando, Florida. In comparison with initial estimates, the cost increases for these projects now range from 66 percent to 427 percent and delays range from 14 to 86 months. Since the 2013 report, some of the projects have experienced further cost increases and delays because of design issues. For example, as of April 2015, the cost for the Denver project increased by nearly $930 million, and the completion date for this project is unknown.

In its April 2013 report, GAO found that VA had taken some actions since 2012 to address problems managing major construction projects. Specifically, VA established a Construction Review Council in April 2012 to oversee the department's development and execution of its real property programs. VA also took steps to implement a new project delivery method, called Integrated Design and Construction, which involves the construction contractor early in the design process to identify any potential problems early and speed the construction process. However, in Denver, VA did not implement this method early enough to garner the full benefits of having a contractor early in the design phase.

VA has taken actions to implement the recommendations in GAO's April 2013 report. In that report, GAO identified systemic reasons that contributed to overall schedule delays and cost increases at one or more of four reviewed projects and recommended ways VA could improve its management of the construction of major medical facilities. In response, VA has issued guidance on assigning medical equipment planners to major medical facility projects who will be responsible for matching the equipment needed for the facility in order to avoid late design changes leading to cost increases and delays; developed and disseminated procedures for communicating to contractors clearly defined roles and responsibilities of the VA officials who manage major medical-facility projects to avoid confusion that can affect the relationship between VA and the contractor; and issued a handbook for construction contract modification (change-order) processing that includes milestones for completing processing of

modifications based on their dollar value and took other actions to streamline the change order process to avoid project delays.

While VA has implemented GAO's recommendations, the impact of these actions may take time to show improvements, especially for ongoing construction projects, depending on several issues, including the relationship between VA and the contractor.

Why GAO Did This Study
VA operates one of the nation's largest health care delivery systems. In April 2013, GAO reported that VA was managing the construction of 50 major medical-facility projects costing between $10 million and hundreds of millions of dollars, including the ongoing project in Denver. This statement discusses VA construction management issues, specifically, (1) the extent to which the cost, schedule, and scope at Denver and other major medical-facility projects has changed and the reasons for these changes, (2) actions VA has taken since 2012 to improve its construction management practices, and (3) VA's response to GAO's recommendations for further improvements in its management of these construction projects. This statement is based on GAO's April 2013 report (GAO-13-302), May 2013 (GAO-13-556T), April 2014 (GAO-14-548T), and January 2015 (GAO-15-332T) testimonies, and selected updates on VA projects—located in Denver, Colorado; Las Vegas, Nevada; New Orleans, Louisiana; and Orlando, Florida. To conduct these updates, GAO obtained documentation from VA in April 2015.

What GAO Recommends
In its April 2013 report, GAO recommended that VA (1) develop and implement agency guidance for assignment of medical equipment planners; (2) develop and disseminate procedures for communicating to contractors clearly defined roles and responsibilities of VA officials; (3) issue and take steps to implement guidance on streamlining the change-order process. VA implemented GAO's recommendations.

Vietnam at 50 ► Vietnam Syndrome

The Vietnam War’s lasting impact on America’s foreign policy is largely characterized by doubt, in the opinions of many analysts. Doubt that the United States, despite possessing the most powerful military on earth, will win a war against a determined enemy. Doubt among presidential administrations that the public would support a conflict, once television showed them pictures of dead soldiers being dragged through the streets of countries most Americans knew little or nothing about. Mostly, doubt — with some notable outliers — that the United States can impose its will through force, no matter the situation. Driving those doubts is the desire to avoid another open-ended commitment with an uncertain endgame, where U.S. troops spend years on the ground in a foreign country, fighting against an enemy that can blend back into the civilian population far too easily. That desire is part of what some have defined as “Vietnam syndrome,” a concept declared dead and reborn several times in the decades since the last American combat troops left Southeast Asia.

“Getting involved and not being able to get up, like Gulliver tied down by the Lilliputians suffering constant blows, that’s the concern,” said Carlyle Thayer, an American professor and Vietnam analyst who taught a course on the Vietnam War at Australia’s National Defense University. That concern endures — buffeted by experiences in Iraq and Afghanistan — as Americans debate today’s military actions. Americans support fighting the Islamic State group by a 60 percent to 31 percent margin — unless that action turns to ground troops, according to a September Gallup poll. Only 40 percent approve of that, according to the poll.

President Barack Obama went so far as to rule out U.S. ground troops before the latest round of air and naval strikes on Iraq and Syria began. Before the end of the Vietnam War, presidents didn’t speak in such measured, cautious ways about how they would wage war. However, Obama made it clear during a May speech at the U.S. Military Academy that caution would be a cornerstone of his foreign policy agenda “Since World War II, some of our most costly mistakes came not from our restraint, but from our willingness to rush into military adventures without thinking through the consequences,” Obama said. The U.S. would act unilaterally when it was directly threatened and would otherwise explore other options, he said. Obama, 53, is too young to have served in Vietnam — yet his words that day mirror the definition of Vietnam syndrome offered by journalist and Vietnam War author Marvin Kalb, who called it “a fundamental reluctance to commit American military power anywhere in the world, unless it is absolutely necessary to protect the national interests of the country.”

The term Vietnam syndrome first reached prominence when presidential candidate Ronald Reagan used it during an August 1980 campaign speech. Reagan said the syndrome was created by the “North Vietnamese aggressors” aiming to “win in the field of propaganda here in America what they could not win on the field of battle in Vietnam.” In Reagan’s view, America failed to secure Vietnam because it lacked the means and the will to do so from the home front. Nevertheless, fear of another Vietnam “quagmire” became the lens through which military action was viewed in the post-war 1980s. Although Reagan’s budgets dramatically increased defense spending, his military actions were generally small, covert or obtained by proxy.
Then came the first Gulf War. It was civilian America’s first look at the reconstituted, all-volunteer force in a very large-scale action. Victory came swiftly and at the cost of relatively few casualties. President George H.W. Bush avoided the quagmire by pulling troops out of Iraq quickly and leaving Saddam Hussein in power — moves that drew little criticism at the time. Basking in the afterglow of military triumph, Bush ended a speech in 1991 with the proclamation that, “By God, we’ve kicked the Vietnam syndrome once and for all.”

About two years later, the doubts that Vietnam brought about returned, this time in the Horn of Africa. On Oct. 3, 1993, the “Black Hawk Down” incident kicked off the Battle of Mogadishu, leaving 18 U.S. servicemembers dead. Americans recoiled at images of Staff Sgt. William David Cleveland’s body being dragged through the Somali capital’s streets. Days later, Clinton ordered U.S. troops to begin preparing for withdrawal. A year later, the genocide in Rwanda began, and Clinton sent no military force. He would later describe not intervening in the genocide, which claimed about 1 million Rwandans, as one of his biggest regrets. “If we’d gone in sooner, I

believe we could have saved at least a third of the lives that were lost. … It had an enduring impact on me," Clinton said on CNBC in 2013.

American overseas involvement remained somewhat restrained up until the aftermath of the 9/11 attacks. After that, eight out of 10 Americans supported a ground war in Afghanistan. If President George W. Bush had any worries about Vietnam syndrome, he didn't share them publicly. Defense analysts once again declared Vietnam syndrome kicked, at least, until the wars in Iraq and Afghanistan grew protracted, and opinion polls turned against the conflicts. In 2009, conservative scholar Max Boot said that George H.W. Bush got it wrong with his 1991 proclamation — Vietnam syndrome was alive and well in the Obama era.

Boot noted several examples of lawmakers and analysts questioning the wars in Iraq and Afghanistan through the prism of Vietnam. Boot dismissed their doubts as defeatist. He saw no reason to make the Vietnam comparison, unless it was to compare administrations "more interested in ending than in winning the war." Boot's view led him to agree on one point with Obama's assessment: "You never step into the same river twice. And so Afghanistan is not Vietnam." [Source: Stars and Stripes | Erik Slavin | Nov. 12, 2014++]

Brain Injury ► Awareness TRICARE Coverage

The Military Health System continues to emphasize Brain Injury Awareness this month. Learning about brain injury can not only help prevent unnecessary injury, but can help you understand different types of injuries and how you can help someone who has experienced a brain trauma. Brain injuries affect millions of Americans each year. Just as no two people are exactly alike, no two brain injuries are exactly alike. After an impact to the head, a person with a brain injury can experience a variety of symptoms. Brain injuries can be classified as acquired or traumatic.

- An acquired brain injury is an injury to the brain, which is not hereditary, genetic, progressive, or initiated by birth trauma. While a traumatic brain injury (TBI) can be considered an acquired brain injury, traumatic brain injuries are caused by an external force.
- A concussion is the most common type of traumatic brain injury. A concussion can be caused by direct blows to the head, gunshot wounds, violent shaking of the head, or force from a whiplash type injury. This type of injury occurs because the brain receives an impact or a sudden momentum or movement change. A person with a concussion may or may not experience a brief loss of consciousness. A concussion may or may not show up on a diagnostic imaging test, such as a CAT scan so it is important to know the symptoms of a brain injury and watch the person who has experienced any trauma to their head. You can get a contusion from a direct blow to the head; the contusion is specifically, the bruise (bleeding) on the brain.

Many think that getting a brain injury is hard to do, but the opposite is true. According to the Centers for Disease Control and Prevention (CDC), the leading cause of traumatic brain injury is falls. The brain is not a hard, fixed substance. It is soft and jello-like in consistency, composed of millions of fine nerve fibers, and "floats" in cerebral-spinal fluid within our skull. When the head is struck suddenly, strikes a stationary object, or is shaken violently, this force is transmitted to the brain causing injury like concussions, contusions or any number of injuries.

Cognitive rehabilitation therapy (CRT) is an umbrella term that refers to a collection of therapy techniques that may be used to help improve an individual's cognitive (i.e. thinking) abilities after a brain injury, including TBI. TRICARE does not cover CRT as a stand-alone therapy because some of the treatments have not met TRICARE Standards of coverage as fully safe and effective. However, TRICARE offers a comprehensive rehabilitation benefit that includes occupational therapy (OT), physical therapy (PT), speech therapy and behavioral health services when ordered by a physician as part of a comprehensive individual rehabilitation treatment plan. Individual therapists commonly incorporate CRT techniques into covered services which are reimbursed under each separate therapy. For more information, visit the Cognitive Rehabilitation Therapy page on the TRICARE website at http://www.tricare.mil/CoveredServices/IsItCovered/CogRehabTherapy.aspx. For specific coverage details, contact your regional contractor. [Source: TRICARE Communications | March 25, 2015 ++]